STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155364	A. BUILDING _____ B. WING _____	C 02/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BYRON HEALTH CENTER	12101 LIMA ROAD FORT WAYNE, IN 46818

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00085366. Complaint IN00085366- Unsubstantiated due to lack of evidence. Unrelated deficiency cited at F223, F225, F226 Survey dates: February 8, 9, 2011 Facility number: 000255 Provider number: 155364 AIM number: 100273280 Survey team: Ann Armey, RN Census bed type: NF: 125 SNF/NF: 3 Total: 128 Census payor type: Medicare: 3 Medicaid: 121 Other: 4 Total: 128 Sample: 6 This deficiency also reflects State Findings cited in accordance with 410 IAC 16.2. Quality review completed on February 11, 2011 by Bev Faulkner, RN	F 000	This Plan of Correction will serve as the written allegation of compliance. Preparation and/or execution of the plan-of correction does not constitute admission or agreement by Byron Health Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The POC is prepared as a provision of federal/state regulations RECEIVED MAR - 1 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
F 223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION	F 223		

app 3/3/11 BM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Admw. | (X6) DATE: 2-28-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure residents were free from mistreatment and abuse and to prevent continued mistreatment; in that facility staff failed to report immediately and suspend an employee when mistreatment was first observed for 1 of 2 allegations of abuse reviewed which involved 1 of 1 residents in a sample of 6. (Resident #B). Findings include: On 2/8/11 at 4:00 a.m., the Director of Nursing (DON) indicated they had to terminate an employee, CNA #10, following an allegation of abuse. The DON indicated she did not feel the employee's behaviors had been "willful" but the employee lacked "insight" and her approaches towards the residents had not been appropriate. The employee record of CNA #10 was reviewed on 2/9/11 at 9:30 a.m., and indicated she was hired on 5/7/09 and was suspended on 1/18/11, following an allegation of abuse. CNA #10 was subsequently terminated on 1/21/11, following an investigation. An investigative statement from LPN #11, who submitted the written allegation against CNA #10,	F 223	1. The facility suspended CNA #10 on 1-18-11 for follow up investigation of allegations of resident abuse of resident B. 2. All residents of unit that CNA #10 worked on were reviewed and there were no other indications of resident abuse to other residents. 3. Neglect / Abuse policy was reviewed and found to be in accordance with state regulations (See Attachment F223-A) to cover Neglect / Abuse including identifying and reporting. 4. Monitoring will occur by reviewing all incident reports quarterly and reporting findings to the facility QI committee. 5. Date certain: 3-11-11	

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F 223	Continued From page 2 dated 1/18/11, indicated, in part, the following incidents: On 1/18/11 (no time listed), Resident #B was wandering in and out of rooms and CNA #10 grabbed Resident #B by the belt on her pants and "dragged her" out of the room. CNA #10 then told Resident #B that she did not have time for this "crap." On 1/18/11 (no time listed) Resident #B was ambulating in the hall holding clean linens and CNA #10 walked up to the resident and "jerked away" the linens without saying anything to the resident. On 1/18/11 (no time listed), Resident #B had been incontinent of urine and CNA #10 told Resident #B in front of other residents "I know you know better than that!" On 1/18/11 (no time listed), Resident #B was sitting in the dayroom and CNA #10 told the resident it was time for bed. When Resident #B attempted to refuse, CNA #10 assisted her to bed. The resident was yelling and came out of the room with a skin tear and hematoma on the right forearm. A statement from CNA#10, (undated no times listed) regarding the incidents on 1/18/11, indicated in part the following: Resident #B was wandering in and out of rooms and was holding onto another resident's rail so she (CNA #10) "gently steered her out of the room." Resident #B did not have a history of incontinence and the incident about her (CNA	F 223		

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F 223	Continued From page 3	F 223		

#10) telling the resident she should know better "never occurred." Resident #B was incontinent only one time on the shift and LPN #11 did not witness the care provided. LPN #11 only knew about the incontinence incident because she (CNA #10) had written a behavior slip.

Resident #B was removing pictures from the wall and attacked CNA #13. CNA #10 and CNA #13 walked with the resident to her room and laid her down in bed.
After 10-15 minutes, the resident came out of the room and showed me her forearm was bleeding. LPN #11, then declared that she was reporting her to the supervisor.
CNA #10 indicated two CNAs put the resident to bed but she was the only one suspended and she did not hurt the resident.

A statement from CNA #13, dated 1/21/11, regarding the incidents on 1/18/11, indicated, in part, the following:
CNA #13 reported to the secured unit on which CNA #10 was working and Resident #B resided, at 7:30 p.m. and covered the unit until 8:20 p.m. Resident #B was not aggressive.

CNA #13 returned to the unit at 10:20 p.m., and Resident #B was taking pictures off the wall and when redirected, Resident #B became aggressive toward CNA #10. The resident was redirected toward her room, got into bed, and covered her head with a blanket. The resident had no injuries at that time. CNA #13 then left the unit.

The clinical record of Resident #B was reviewed on 2/8/11 at 2:50 p.m. and indicated the resident

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F 223	Continued From page 4 was admitted on 8/13/08, with diagnoses which included but were not limited to, severe dementia. The quarterly MDS (Minimum Data Set) Assessment, dated 1/31/11, indicated the resident had received a score of 7 of 15 on the cognitive brief interview of mental status indicating she had sever cognitive impairment. The MDS indicated Resident #B had behaviors of physical abuse and wandering. Nursing notes, on 1/18/11 indicated the following: At 6:15 p.m., Resident #B was incontinent of urine and when the CNA attempted to provide care, the resident became combative and could not be redirected. The resident was given Ativan (a medication for restlessness). At 7:30 p.m., Resident #B was pleasant and interacting with staff. At 10:30 p.m., Resident #B showed staff that she had a skin tear on her right forearm and purple discolorations around the skin tear. The supervisor was notified and treatment orders were obtained. At 11:50 p.m., the skin tear was described as 4 cm with a 5 cm by 4 cm hematoma on the right posterior lower arm. The investigative summary conclusion, (undated), signed by the administrator, was reviewed on 2/9/11 at 11:20 p.m. The summary indicated, in part, "follow up investigation determined that while no actual abuse or neglect was directly observed or witness (sic) , the potential for such existed. (CNA #10's name) was known and observed handling and assisting residents with less control then (sic) necessary... while we were not able to verify that actual abuse	F 223		

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F 223	Continued From page 5	F 223		

and or harm was received by residents the decision was made to terminate (CNA #10's name) on 1-21-'11...Information was reported to ISDH CNA Registry but actual abuse or neglect was not reported as it was never observed or verified..."

On 2/9/11 at 3:30 p.m., LPN #11, who worked on the secure unit on 1/18/11, was interviewed.
The nurse indicated CNA #10 was acting very frustrated toward Resident #B and her approach to the resident "was all wrong." She indicated she told CNA #10 that the resident had been a nurse and needed to keep busy. She indicated it caught her attention when CNA #10 was kind to Resident #B while a family was on the unit but then her whole demeanor changed when the family left. LPN #10 said she decided to call the supervisor when Resident #B came out of her room with a skin tear. She indicated that she did not actually see CNA#10 hurting the resident.

On 2/9/11 at 3:45 p.m., CNA #13, who provided relief on the secure unit on 1/18/11, was interviewed.
CNA #13 indicated Resident #B was taking down pictures but seemed fine. The CNA indicated nothing unusual happened.

The policy for the investigation of abuse and protection of residents, updated 8/13/10, provided by the executive director, was reviewed on 2/9/11 at 11:45 a.m. and indicated:
"This facility recognizes that abuse may include:
Physical Abuse
Sexual Abuse
Emotional Abuse
Medical Neglect

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F 223	Continued From page 6 Emotional Neglect Self Neglect Financial or Material Exploitation Violation of Personal Rights Abandonment... Upon the allegation or the identification of abuse neglect, or misappropriation of resident property, the administrator will be immediately informed and the facility shall immediately undertake an investigation. Byron Health Center will seek to assure the safety of the resident involved... ...3. Staff incidents which involve abuse, neglect, involuntary seclusion and/or misappropriation of resident property are investigated as follows... a. The staff member is suspended immediately...	F 223		
F 225 SS=D	3.1-27(b) 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225	1. The facility has since reported this allegation of suspected abuse to appropriate agencies in accordance with state regulations. 2. No other residents were affected by this deficient practice. 3. Policy on Neglect / Abuse was reviewed and found to be in accordance with state requirements. Inservices were scheduled to cover Neglect / Abuse including reporting has been completed.	

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F 225	Continued From page 7 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure staff reported immediately allegations of mistreatment to the administrator and the administrator failed to report the allegations to the appropriate state agencies including the Indiana State Department of Health. This deficiency involved 1 of 2 investigations of abuse reviewed, 1 of 3 employees reviewed, who were terminated (CNA #10), and 1 resident of 1 resident involved in an abuse investigation in a sample of 6 (Resident #B). Findings include: On 2/8/11 at 4:00 a.m., the Director of Nursing (DON) indicated they had to terminate an employee, CNA (Certified Nursing Assistant) #10, following an allegation of abuse. The DON indicated she did not feel the employee's	F 225	4. Monitoring will occur by reviewing all incident reports quarterly and reporting findings to the facility QI committee. Additionally, all known reports of suspected abuse / neglect will be reviewed monthly to make sure that all appropriate / required reporting has been completed. 5. Date certain: 3-11-11	

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F 225	Continued From page 8	F 225		

behaviors had been "willful" but the employee lacked "insight" and her approaches towards the residents had not been appropriate.

The employee record of CNA #10 was reviewed on 2/9/11 at 9:30 a.m., and indicated she was hired on 5/7/09 and was suspended on 1/18/11, following an allegation of abuse. CNA #10 was subsequently terminated on 1/21/11, following an investigation.

An investigative statement from LPN #11, who submitted the written allegation against CNA #10, dated 1/18/11, indicated, in part, the following incidents:
On 1/18/11 (no time listed), Resident #B was wandering in and out of rooms and
CNA #10 grabbed Resident #B by the belt on her pants and "dragged her" out of the room. CNA #10 then told Resident #B that she did not have time for this "crap."

On 1/18/11 (no time listed) Resident #B was ambulating in the hall holding clean linens and CNA #10 walked up to the resident and "jerked away" the linens without saying anything to the resident.

On 1/18/11 (no time listed), Resident #B had been incontinent of urine and CNA #10 told Resident #B in front of other residents "I know you know better than that!"

On 1/18/11 (no time listed), Resident #B was sitting in the dayroom and CNA #10 told the resident it was time for bed. When Resident #B attempted to refuse, CNA #10 assisted her to bed. The resident was yelling and came out of the room with a skin tear and hematoma on the right

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F 225	Continued From page 11 posterior lower arm. The investigative summary conclusion, (undated), signed by the administrator, was reviewed on 2/9/11 at 11:20 p.m. The summary indicated, in part, "follow up investigation determined that while no actual abuse or neglect was directly observed or witness (sic) , the potential for such existed. (CNA #10's name) was known and observed handling and assisting residents with less control then (sic) necessary... while we were not able to verify that actual abuse and or harm was received by residents the decision was made to terminate (CNA #10's name) on 1-21-'11...Information was reported to ISDH CNA Registry but actual abuse or neglect was not reported as it was never observed or verified..." On 2/9/11 at 11:30 a.m., the Administrator was interviewed and indicated the allegation of abuse and subsequent investigation was not reported to the ISDH as a reportable incident but had been reported to the CNA registry. On 2/9/11 at 3:30 p.m., LPN #11, who worked on the secure unit on 1/18/11, was interviewed. The nurse indicated CNA #10 was acting very frustrated toward Resident #B and her approach to the resident "was all wrong." She indicated she told CNA #10 that the resident had been a nurse and needed to keep busy. She indicated It caught her attention when CNA #10 was kind to Resident #B while a family was on the unit but then her whole demeanor changed when the family left. LPN #10 said she decided to call the supervisor about CNA #10's behavior when Resident #B came out of her room with a skin tear. She	F 225		

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F 225	Continued From page 12 indicated that she did not actually see CNA#10 hurting the resident. On 2/9/11 at 3:45 p.m., CNA #13, who provided relief on the secure unit on 1/18/11, was interviewed. CNA #13 indicated Resident #B was taking down pictures but seemed fine. The CNA indicated nothing unusual happened. 3.1-28(c)	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on Interview and record review, the facility failed to follow their policy to report an alleged case of abuse of a resident by a staff person. This deficiency involved 1 of 2 investigations of abuse reviewed, 1 of 3 employees reviewed, who were terminated (CNA #10), and 1 resident of 1 resident involved in an abuse investigation in a sample of 6 (Resident #B). Findings include: On 2/8/11 at 4:00 a.m., the Director of Nursing (DON) indicated they had to terminate an employee, CNA #10, following an allegation of abuse. The DON indicated she did not feel the employee's behaviors had been "willful" but the employee lacked "insight" and her approaches	F 226	1. The policy was not explicitly followed in this instance but will be followed in the future. 2. No other residents were affected by this deficient practice. 3. Neglect / Abuse policy was reviewed and found to be in accordance with state requirements and regulations. 4. Monitoring will occur by reviewing all incident reports quarterly and reporting findings to the	

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F 226	Continued From page 13 towards the residents had not been appropriate. The employee record of CNA #10 was reviewed on 2/9/11 at 9:30 a.m. and indicated she was suspended on 1/18/11, following allegations of abuse and was terminated on 1/21/11. The investigative summary conclusion, (undated), signed by the administrator, was reviewed on 2/9/11 at 11:20 p.m. The summary indicated "follow up investigation determined that while no actual abuse or neglect was directly observed or witness (sic) , the potential for such existed. (CNA #10's name) was known and observed handling and assisting residents with less control then (sic) necessary... while we were not able to verify that actual abuse and or harm was received by residents the decision was made to terminate (CNA #10's name) on 1-21-'11...Information was reported to ISDH CNA Registry but actual abuse or neglect was not reported as it was never observed or verified..." On 2/9/11 at 11:30 a.m., the Administrator was interviewed and indicated the allegation of abuse and subsequent investigation were not reported to the ISDH as a reportable incident but had been reported to the CNA registry. The policy for the investigation of abuse and protection of residents, updated 8/13/10, provided by the executive director, was reviewed on 2/9/11 at 11:45 a.m. and indicated: "...3. Staff incidents which involve abuse, neglect, involuntary seclusion and/or misappropriation of resident property are investigated as follows... b...Indiana State Department of Health (ISDH),	F 226	facility QI committee. Additionally, all known reports of suspected abuse / neglect will be reviewed monthly to make sure that all appropriate / required reporting has been completed. 5. Date certain: 3-11-11	

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F 226	Continued From page 14 and the Ombudsman is notified within 24 hours... e. A written report is sent to the ISDH, APS, and LTC Ombudsman within 5 days. 3.1-28(a)	F 226		